STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	C 10/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE WEST	331 SW OAKLEY TOPEKA, KS 66606

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F 000	INITIAL COMMENTS The following citiation represents the findings of complaint investigations #79083 and79506.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 46 residents. The sample included 1 resident. Based on observation, record review, and interview the facility failed to provide secure environment to prevent elopement for 1 (#1) of 1 of the sampled resident. Findings included: - The quarterly Minimum Data Set (MDS) dated 7/9/14 for resident #1 revealed short term and long term memory problems and moderately impaired cognitive skills for daily decision making. He/she displayed signs and symptoms of delirium (sudden severe confusion, disorientation and restlessness) as evidenced by continuously present inattention and disorganized thinking. The resident also displayed potential indicators of psychosis (any major mental disorder characterized by a gross impairment in reality testing) including delusions (untrue persistent belief or perception held by a person although	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1	F 323		

evidence shows it was untrue) and hallucinations (sensing things while awake that appear to be real, but the mind created). During the 7 day look back period the resident received 7 doses of an antipsychotic (medication used for the treatment of psychosis) and 7 doses of an antianxiety (medication used for the treatment of anxiety; mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The 10/17/13 Care Area Assessment for cognitive loss and dementia (progressive mental disorder characterized by failing memory, confusion) revealed the resident had a diagnosis of Schizoaffective Disorder (SAD; a mental condition that causes both a loss of contact with reality (psychosis) and mood problems) which affected his/her cognition by distorting his/her perceptions and ability to process information adequately. The resident had short and long term memory impairement and he/she was forgetful at times. He/she required reminders for medications, meal times, to brush his/her teeth and hair, appointments, and required assistance with making appropriate decisions, redirection from repetitive and/or inappropriate behaviors, occasional reorientation, and prompting to wear weather appropriate clothing.

The care plan with a revision date of 9/26/14 revealed staff discouraged the resident from taking out the trash and exiting the building to prevent elopements. On 9/7/14 the resident left the facility and walked to a hospital. Upon return staff initiated 15 minute checks. On 9/8/14 the resident reported to staff he/she walked to the hospital due to feeling unsafe with the upcoming anniversary of 9/11. If staff noted expressions or gestures of wanting to leave the facility they initiated 15 minute checks until it was no longer

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F 323	Continued From page 2	F 323		

an issue. On 9/25/14 the resident left the facility and social services brought back to the facility. He/she was evaluated by the hospital due to increased delusions, and placed on 15 minute checks with no trash duties to take the trash outside. The physician adjusted his/her medications and staff monitored the resident for lethargy or stumbling.

The risk for elopement and wandering reviews dated 10/4/13, 1/13/14, 4/18/14, and 7/9/14 revealed the resident was at risk for elopement.

The nursing data collection tool dated 6/2/14 revealed the resident was not able to make decisions based on his/her psychotic and disorganized thinking. The form also indicated the resident continued to be psychotic and delusional, and remained at risk for elopement due to him/her frequently taking out the trash.

The nurses' note (NN) dated 9/7/14 at 10:00 P.M. revealed a direct care staff member notified the nurse he/she was unable to locate the resident. Staff searched the building and drove through the neighborhood. Staff notified the administrator and police.

The NN dated 9/7/14 at 11:37 P.M. revealed hospital security called the facility at approximately 11:25 P.M. and informed them the resident was at the hospital (a distance of 2.7 miles from the facility). The resident reported to security that he/she wanted to see his/her physician there.

The NN dated 9/8/14 at 12:04 A.M. revealed hospital staff notified the facility the resident was not able to be admitted at that time.

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F 323	Continued From page 3	F 323		

The NN dated 9/8/14 at 12:07 A.M. revealed the resident returned to the facility, staff escorted him/her back to his/her room, and staff initiated 15 minute checks.

The social services note dated 9/8/14 at 2:06 P.M. revealed staff notified the social worker the resident walked to the hospital on the previous evening. The resident was not admitted to the hospital at that time, but was to be admitted the next day. The social worker transported the resident to triage at the hospital on the morning of 9/8/14. The note showed the resident reported to the social worker he/she took the most direct route to the hospital which was well lit and had signals for crossing intersections. The resident desired to be the in the hospital until the 15th or 20th of the month to get passed the day the terrorists attacked the world trade center. The resident reported he/she walked to the hospital for his/her own safety. He/she admitted to the hospital for evaluation.

The NN dated 9/16/14 at 11:30 A.M. revealed the resident returned to the facility. Per facility staff he/she seemed glad to be back and was emptying trash and wandering through the facility per his/her usual routine. The hospital planned a phone follow up within 7 days and an appointment with mental health in 14 days.

The NN dated 9/18/14 at 12:57 P.M. revealed the facility received a call from an off-duty staff member that the resident was on 9th street and MacVicar Avenue (a distance of 1.1 miles from the facility) and refused to go back to the facility. The staff member stayed with the resident until the social worker was able to go and assist with the resident. The social worker notified the nurse that he/she took the resident to the hospital at

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F 323	Continued From page 4 12:15 P.M. The hospital psychiatric nurse notified the facility nurse the resident and his/her medications were being evaluated by a physician. The NN dated 9/18/14 at 9:30 P.M. revealed the resident was not admitted to the hospital and released to the facility social worker but the resident refused to get into the car. Security assisted the resident into the vehicle. Upon return to the facility, staff placed the resident on 15 minute checks. The NN dated 9/19/14 at 2:11 A.M. revealed staff provided 15 minute checks and elopement precautions for the resident. Review of the 15 minute check forms provided by the facility revealed staff monitored the resident every 15 minutes on 9/18/14, 9/19/14, 9/20/14, 9/21/14, 9/22/14, 9/23/14, and 9/24/14. The facility was unable to locate documentation of 15 minute checks prior to 9/18/14. Observation on 9/24/14 at 9:35 A.M. revealed the resident swept the patio of the facility's outdoor courtyard. Multiple other residents and 2 staff members were present. The gate to the courtyard was secured with a chain and combination lock. Interview on 9/24/14 at 8:23 A.M. with administrative staff A revealed staff reviewed documentation for the resident's first elopement and spoke with the residentwhen he/she left the facility to go the hospital due to feeling safer at the hospital for 9/11. Staff believed the resident eloped through the courtyard gate, which was not locked. Staff felt the resident's risk for elopement decreased after he/she returned to the facility following the first elopement since they were able to identify the resident's reasons for leaving the	F 323		

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F 323	Continued From page 5	F 323		

facility. The staff identified the reason for the elopement was the resident felt unsafe and wanting to be in the hospital during 9/11, which staff provided. The resdient's second elopement occurred on 9/18/14 at approximately 11:40 A.M. An off duty direct care staff member observed the resident at the corner of 9th street and MacVicar and notified the facility via a phone call. Staff picked up the resident and took him/her to the hospital per the resident's request. The hospital staff evaluated the resident but he/she was not admitted. After the second elopement the facility staff initiated 15 minute checks on the resident.

Interview on 9/24/14 at 1:25 P.M. with administrative nursing staff D revealed this resident was the facility's only current resdient identified at risk for elopement. He/she reported the facility tried to only accept residents that were not elopement risks since they are not a locked facility. If a resident was known for exit seeking the facility recommended them to go to another facility that was more secure.

Interview on 9/24/14 at 1:40 P.M. with licensed nursing staff H revealed he/she was present at the facility for the elopements. Staff H stated the facility staff always monitored the resident closely when he/she went to the dumpster to take out the trash. Staff H reported the resident left the facility through the courtyard gate for both elopements. Staff H could not recall if staff initiated 15 minute checks indefinitely after the first elopement, but was sure staff performed 15 minute checks after the first elopement until the resident admitted to the hospital the next day. Staff H expected staff to follow interventions listed on the care plan and did not believe the facility had pictures of the residents in case of an elopement.

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F 323	Continued From page 6 Interview on 9/24/14 at 1:50 P.M. with direct care staff O revealed he/she was present for the resident's second elopement. Staff O reported no alarms sounded and staff believed the resident left through the courtyard gate. Staff O stated after the second elopement staff placed a lock on the gate and initiated15 minute checks. Interview on 9/24/14 at 2:05 P.M. with administrative staff A revealed staff performed 15 minute checks after the first elopement until the resident admitted to the hospital the following day. Staff A acknowledged the care plan lacked evidence of this, and staff A stated the care plan should include time frames that staff performed the 15 minute checks after the first elopement and prior to his/her admission to the hospital the following morning. Interview on 9/24/14 at 2:45 P.M. with administrative staff A revealed the facility was unable to locate documentation showing that staff performed 15 minute checks between the time of the first elopement and the resident's admission to the hospital. Interview on 9/24/14 at 3:08 P.M. with direct care staff P revealed staff initiated 15 minute checks after the resident's second elopement. The facility also placed a lock on the courtyard gate and provided the combination to all staff to place on the back of their nametags. Staff P reported the facility did not have a binder with residents ' photos. Interview on 9/24/14 at 3:13 P.M. with licensed nursing staff I revealed after the resident ' s elopements the facility had an inservice regarding elopements and a drill. Staff I reported the facility did not have a binder with residents ' photos but	F 323		

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F 323	Continued From page 7 stated the director of nursing had talked about starting one. Interview on 9/24/14 at 3:27 P.M. with administrative nursing staff D the care plan was unclear on the timeframe for 15 minute checks. Staff D stated he/she expected the care plan to have consistency. He/she also reported the facility had plans to start a photo binder for resident's at risk for elopement, and acknowledged the facility was not following their current policy for elopement which showed the facility was to have a photo binder already in place. The policy provided by the facility regarding elopement with a revision date of August 2012 revealed the facility strived to provide a safe environment and preventative measures for elopement, including stored printed photographs, labeled with resident names and room numbers in a binder. The facility failed to provide a secure environment to prevent elopements for this resident with noted hallucinations and delusions, and identified at risk for elopement.	F 323		